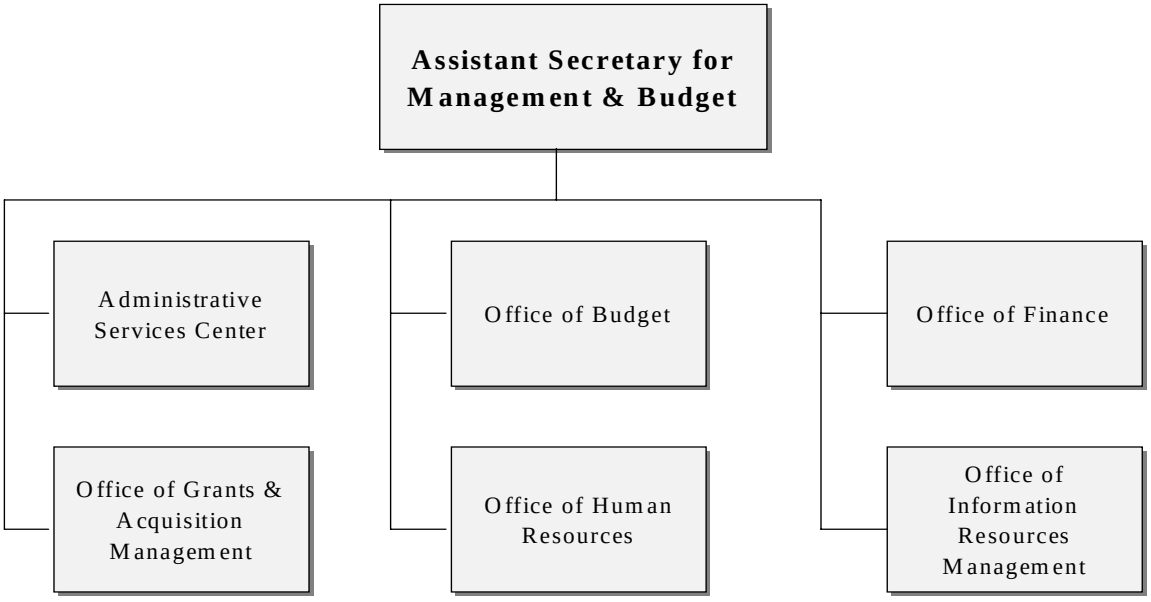
SECTION III:

OVERVIEW OF FINANCIAL MANAGEMENT: ISSUES AND ACCOUNTABILITY

Overview of Financial Management: Issues and Accountability

FINANCIAL MANAGEMENT RESPONSIBILITY AND ORGANIZATION

Given that HHS had net outlays of $339.5 billion in FY 1997 (21.5% of the Federal budget), we have an enormous responsibility for financial accountability. HHS is a key player in the Governmentwide financial statement audit, which was prepared for the first time for FY 1997. In 1993, this Administration first promoted the idea of a Governmentwide financial statement audit in the Vice President's National Performance Review accompanying report on "Improving Financial Management" (Recommendation FM 10.1). The Administration also strongly supported the Government Management Reform Act (GMRA) of 1994, which amended the CFO Act of 1990, and expanded financial statement audit coverage to include Departmentwide and Governmentwide audited financial statements. This Accountability Report demonstrates our involvement in, and our dedication to, this Administration's commitment to strong financial management. All HHS managers with responsibility for Federal resources are, to some degree, financial managers. However, official responsibility for financial management matters is delegated from the Secretary to the Chief Financial Officer (CFO) who also holds the title of Assistant Secretary for Management and Budget (ASMB). The ASMB, who is appointed by the President and confirmed by the U.S. Senate, also serves as the Chief Information Officer (CIO). The Offices of the ASMB are illustrated in the accompanying organization chart.



The Office of Finance is headed by the Deputy Assistant Secretary for Finance, who also serves as the Deputy Chief Financial Officer (DCFO). This office is responsible for implementation of an ever-increasing volume of Federal financial legislation and initiatives within an environment of evolving technologies, limited staffing, and cost containment. The list of financial management legislation includes:

Prompt Pay Act of 1982
Federal Managers Financial Integrity Act (FMFIA) of 1982
Chief Financial Officers (CFOs) Act of 1990
Cash Management Improvement Act (CMIA) of 1990
Government Performance and Results Act (GPRA) of 1993
Government Management Reform Act (GMRA) of 1994
Federal Financial Management Improvement Act (FFMIA) of 1996
Debt Collection Improvement Act (DCIA) of 1996
Information Technology Management Reform Act (ITMRA) of 1996

The Office of Finance has responsibility (in partnership with our OPDIVs) for many new and ongoing initiatives such as: developing and implementing accounting and financial policies, systems and reports; resolving audit findings; implementing financial and program performance measurement; prompt payment; budget execution; improving reliability of financial information; policy development and coordination for debt collection; implementing all financial management legislation; and integrating all of the financial management initiatives. These initiatives are coordinated with the various OPDIVs of HHS through the policy-level HHS CFO Council and the operational-level Financial Policies Group (FPG). Accounting operations were moved from the Office of Finance to the Program Support Center (PSC) in the 1995 HHS reorganization.

HIGHLIGHTS OF FY 1997 ACCOMPLISHMENTS AND FINANCIAL MANAGEMENT STATUS

HHS has developed five strategic goals for financial management that will help build the Department's infrastructure and carry out its mission. The FY 1997 HHS Financial Management Status Report and Five-Year Plan is organized by these goals. The goals, and a brief description of their status as of the end of FY 1997, are presented in the accompanying chart.

Strategic Financial Management Goals	Fiscal Year End (FYE) 1997 HHS Status/Accomplishments
1. Managing for Performance Results	• Developed GPRA strategic plan and consulted with Congress and other stakeholders. • Submitted annual performance plans for FY 1999 to OMB. • Continued sponsorship of the HHS-wide GPRA Roundtable and co-sponsored the Government-wide Research Roundtable. • Initiated a Regulatory Roundtable with the Environmental Protection Agency. • Continued to identify and correct management control deficiencies under FMFIA.
2. Strengthening Business Practices for the 21st Century	• CDC selected new procurement system with EDI capability. • FDA implemented on-line accounting transaction processing capabilities at headquarters. • Launched numerous Internet Web sites to serve the public with health information, and information on agency services. • Continued support of FinanceNet. • Completed an assessment of the scope of the Year 2000 problem. • Implemented quarterly reporting to monitor EFT progress. • OMB designated the Division of Federal Occupational Health (FOH) as a franchise fund pilot. • Developed the Acquisition Balanced Scorecard.
3. Ensuring Sound Financial Information for Decision Making	• Participated in development of accounting policy with FASAB and Standard General Ledger Issue Resolution Committee. • Issued policy guidance of financial statement preparation. • Conducted Department-wide training session on financial statement preparation. • Expanded CDC and NIH audit coverage. • All OPDIVs prepared financial statements. • Completed the first Department-wide audit covering FY 1996 and published first HHS Accountability Report. • Expanded user access to FIRS data.
4. Managing Assets to Achieve Maximum Return on Investments	• For the 1996 tax year, referred 2,880 consumer debts totaling $89 million to the IRS Tax Refund Offset Program; collected $1.2 million as a result. • Also referred commercial debts totally $36 million; approximately $400 thousand collected as a result. • Over $1 billion in delinquent child support payments were collected by offsets. • Notified 16,000 grantees of offset provisions of DCIA. • Published Federal Register "Notice of an Altered System of Records" to comply with Privacy Act requirements of DCIA. • PSC applied to Treasury to become a designated debt collection center. • HHS-wide prompt payment rate was only 89.7% (up from 89% in FY 1996). • HHS purchase card activity increased 71 percent from 1996 to 1997. • Began implementation of new capital planning guidelines. • ACF completed bar coding and inventory of personal property. • Increased capitalization threshold to $25 thousand. • Personal property disposal implementation system implementation delayed.
5. Exercising Stewardship in Our State and Local Partnerships	• Maintained strong relationships with our partners at many levels: Federal, State, local, tribes, aging networks, etc. • Customer survey reports satisfaction with grants payment management system. • Tested TAGGS prototype software. • Issued new grants policy guidance. • Worked with OMB on a number of grants policy issues. • Issued ASMB C-10, "*Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Agreements with the Federal Government*."

HIGHLIGHTS OF SELECTED FINANCIAL MANAGEMENT ISSUES

STREAMLINING REPORTS

In FY 1997, the Department of Health and Human Services became an official member of the Streamlining Pilot Program of the U.S. CFO Council, under the auspices of the Government Management and Reform Act of 1994. The goal of this effort is to streamline several statutorily required financial reports into one integrated, user-friendly financial report that reflects all of the significant financial information about the reporting entity. (All financial management planning-related reports would be streamlined into the annual Financial Management Five-Year Plan.) The chart below provides the location in this Accountability Report where various "streamlined" reports can be found.

Streamlined Report	Location in 1997 HHS Accountability Report
Annual Financial Statements	Section V
Auditor's Opinion on the Financial Statements	Section VI
Civil Monetary Penalties	Section III
Prompt Payment	Section III
OIG's Semi-Annual Report	Appendix B
Management Report on Final Action	Appendix C
Federal Managers' Financial Integrity Act Reporting (FMFIA)	Appendices D, E, & F
Budgetary Information	Sections I & II, Appendix G
Performance and other GPRA Information (including Healthy People 2000)	Sections I, II, III Appendices A
Financial Management Status Report and Five Year Plan	Section III
Supplementary Information on Medicare Trust Funds	Sections I, II, III, IV
Federal Financial Management Improvement Act of 1996 Reporting (FFMIA)	Section III

ASSET MANAGEMENT

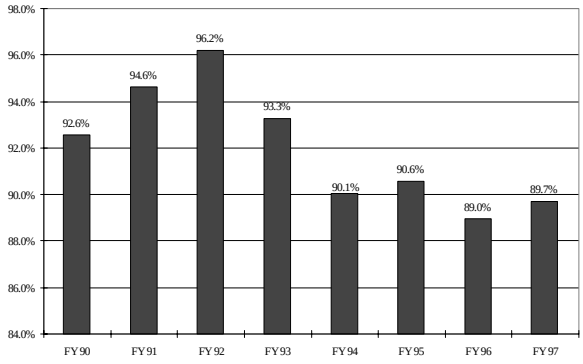
Prompt Pay

An important part of cash management is the prompt payment of vendor invoices and other payables in order to reduce the payment of interest penalties. During FY 1997 HHS:

- paid 1.15 million vendor invoices valued at $3.9 billion
- paid 89.7% of these invoices on time, compared to 89% on time in FY 1996
- paid interest penalties of $806,195 on 4.4% of vendor payments
- paid an average penalty of only $15.93 and an average of $209 in late payment penalties for every $1 million in vendor payments.

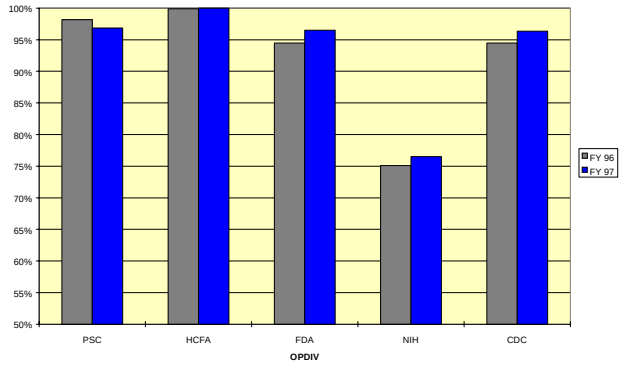
The following chart displays prompt pay performance from FY 1990 to FY 1997. Performance in FY 1997 improved slightly over FY 1996.

HHS Percentage of On-Time Payments



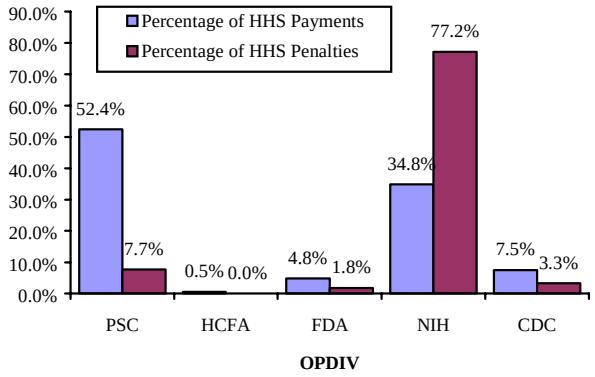
The Department's prompt pay performance hit its record high in 1992. HHS has been unable to maintain this performance level because of a number of factors, most prominent of which are due to resource limitations. The deterioration in on-time payments is due to problems in one agency – NIH. NIH has experienced a series of uncontrollable issues affecting its bill paying capacity. Staffing was reduced from 33 to 17 positions and several key staff left the organization at a critical time while its payment office was implementing a new bill payment system – Viewstar. Additionally, resources available to pay overtime were limited. As the new system was rolled out, a backlog occurred. These and other problems have impacted NIH's ability to improve its prompt payment rates this year. The other four payment offices in HHS have paid between 94.5% and 100% of their vendor payments on time for the last two fiscal years, as shown in the accompanying chart.

Percent of Payments Made On-Time



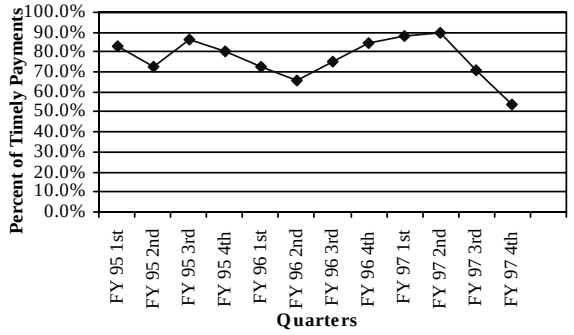
NIH, with 35% of all HHS invoices, is the second largest vendor payment office (with over 500,000 invoices paid each year). This impact is visually represented in the accompanying chart which shows the percent of HHS payments versus the percent of HHS penalties incurred in each payment office in FY 1997.

FY 97 HHS Percent of Payments Vs Percent of Penalties



As noted previously, there are a number of causes for NIH's current problems including staff turnover and the necessary time to fill vacant positions and train new staff, untimely receipt of information from the decentralized 115 procurement offices and automated systems problems. NIH has taken, and continues to take, steps to improve its performance. During FY 1997 NIH staff implemented the first phase of a document imaging system which has the potential to be a major factor in improving prompt pay performance in the future. Unfortunately, due to problems encountered in this phase one implementation there was an initial negative impact on making payments promptly. Due to the various problems and steps taken to improve the situation NIH on time payment performance measured on a quarterly incremental basis has fluctuated quite widely over the last few years. This can clearly be seen in the following chart:

NIH On Time Payment Percentage by Quarter



Debt Collection (Receivables Management)

Accounts receivable are the focus of "debt collection" activity at HHS, as the Department pursues every available avenue to collect debt owed to the Federal Government. HHS remains firmly committed to maximizing resources available for program activities and supporting our program managers who manage over 280 programs by effectively managing our collection processes. The recently enacted Debt Collection Improvement Act (DCIA) of 1996 has significantly enhanced our ability to collect delinquent debts though its implementation has been resource intensive and it has not been without problems. A cross-functional Departmental work group is implementing a capital planning process for the Department to help us achieve maximum return on our capital asset investments. We recognize the need to focus on capital asset and cash management as we prepare our comprehensive financial statements and contribute to the first Governmentwide audited financial statements for FY 1997.

HHS has long been dedicated to recovering, to the maximum extent possible, debts due the Federal Government utilizing collection techniques based on the type of debt and the most cost effective collection mechanism that can be applied to that debt. Some of our more significant accomplishments follow:

- HHS collected over $11 billion owed to the Federal government with another $976 million in the Department of Justice's litigation process.

- For the 1996 tax year, we referred 2,880 consumer debts totaling $89.1 million to the Internal Revenue Service (IRS) Tax Refund Offset Program (TROP); 311 debtors paid $593 thousand as a result of being referred; and 609 debts totaling $650 thousand were recovered as a result of TROP offsets. Also referred to TROP were 397 commercial debts totaling $36.1 million; 31 debtors paid $359 thousand as a result of being referred; and 10 debts totaling $63 thousand were recovered as a result of TROP offsets.

- We assisted the States in referring 4,355,185 cases totaling over $31 billion to the IRS to recover delinquent child support payments for the 1996 tax year. There were 1,240,596 child support offsets with record collections totaling over $1 billion.

- The PSC is providing debt management services to six of the 12 component agencies as part of the Department's effort to achieve service efficiency by consolidating common administrative functions among HHS agencies.

- A Kodak image processing system was selected to better manage PSC documents generated by the numerous debt and credit programs. The new system is expected to generate monetary savings from reductions in storage, filing, and retrieval time as well as document reproduction.

- During the past year, 2,000 debts totaling $59.4 million were referred to private collection agencies. They collected almost $3.9 million.

- HRSA debt prevention initiatives involve the development and distribution of brochures, videos, and debt management workbooks to educate borrowers in managing their money, including the refinancing of loans to save students money. As of FY 1996, more than 40,000 workbooks have been distributed.

- HCFA is also working to prevent receivables, primarily on the front end of the Medicare Secondary Payer (MSP) process. Proposed legislation would require group insurers to provide information that would ensure that Medicare only pays the appropriate share of beneficiary claims, eliminates the time limits for HCFA to file claims against insurers, and requires that insurers reimburse the government for the full amount of the Medicare payment.

- Additionally, HCFA is improving and simplifying its initial enrollment questionnaire and negotiating data sharing agreements with two Fortune 500 companies. These processes will not only reduce costs to process health claims for HCFA but also for the rest of the industry.

The passage of the Debt Collection Improvement Act (DCIA) of 1996 provided agencies with new enhanced collection tools. Under the DCIA we have:

- Established a Department-wide workgroup to implement the provisions of the law with consideration to the impact on current HHS debt management policies and procedures.

- Notified 16,000 grantees of the offset provision of the DCIA and its potential impact on them.

- Published a new "Notice of an Altered System of Records" in the Federal Register to comply with Privacy Act requirements and complete our debt referral process.

- Referred our first debts to Treasury for offset on March 25, 1996, using the existing IRS TROP system. Not including delinquent child support cases, HHS, as one of eight Agencies, referred 2,598 cases totaling $93.8 million to TOP during FY 1997.

- Entered into an agreement with Treasury to refer delinquent debts to the DMSC on February 12, 1997; our first debts were referred on February 26, 1997. Additional debts will be referred on a phased-in basis. However, if PSC is selected as a debt collection center (see below), HHS agencies will refer their debts to the PSC.

- Applied to Treasury to become a designated debt collection center on February 28, 1997. PSC currently provides debt management services to over half of the Department's OPDIVs and has secured commitments to provide services for all OPDIVs during FY 1998.

- Reviewing loan procedures to ensure that delinquent debtors do not receive loans from the Department.

- Worked with its OPDIVs to identify appropriate performance measures for its debt and credit programs. Some measures identified include:

  - Total child support collections,
  - Number and type of collections,
  - Reduction in Medicare overpayments,
  - Maintain uncollectable debt at no more than 1 percent of total reimbursements,
  - Issue 1099C for all debts that are written off,
  - Refer 96 percent or more of all delinquent debts over 180 days old to the Treasury Offset Program, and
  - Refer all eligible customer agency health profession claims for Medicare participation exclusion when claim is referred to Justice for litigation.

- Developed an inventory of all debts owed to the Department and created an asset sales questionnaire to review their suitability for sale in today's marketplace. Aided with advice from the private sector, we have decided not to sell our receivables at this time as none of them are backed by collateral.

- Increased our civil monetary penalties by 10% to adjust them for inflation.

- Worked with the States and Treasury to refer delinquent child support obligations to TOP. To date, 749,204 cases totaling over $8.3 billion from Alaska, Arizona, California, Connecticut, Kansas, Oklahoma, Oregon, South Dakota, and the District of Columbia have been referred to TOP.

Information concerning our plans for improving our debt management activities can be found in our annual Financial Management Five-Year Plan.

Property Management

Property represents a relatively small amount of HHS assets, however, given the size of HHS assets, this still amounts to a significant sum. Property issues are associated with real property for the OPDIVs with multiple locations (IHS, FDA, etc) and with high-tech research equipment at NIH. The financial statement audit process has revealed several areas for improvement related to property management and accounting for property. These issues were applicable to several OPDIVs. Corrective action steps taken have included: improving the inventory process to better locate inventory items, researching documents in order to correctly record property's original costs, and obtaining appraisals of value when historical records could not be found.

TRAVEL

The Office of Finance has continued to be involved with the various Governmentwide initiatives and the travel policies that affect the Department of Health and Human Services. We believe that the travel dollars being spent are important to the public and in some instances receives closer scrutiny by the public than many of the higher dollar volume activities of the Federal Government.

We are continuing to implement the various recommendations of the National Performance Review (NPR) and the Joint Financial Management Improvement Program (JFMIP) as they relate to travel. We believe that the JFMIP travel recommendations, intended to improve Governmentwide travel policies by applying common sense to the development of new policies and guidelines, are good steps in the right direction. We also believe that new policies should also contain a common sense approach and should be tempered with logic and thoughtfulness. To this end, our travel policies will be implemented with accountability on the part of travel managers and our travelers. In this way, the tax paying public can be assured that tax dollars are not being wasted.

During the past year HHS has made significant progress in reducing delinquencies of the Government provided travel charge card. This has been accomplished primarily though increased attention on the type of charges made using the travel charge card and working with the contractor to identify and address potential payment problems before they become delinquent.

CIVIL MONETARY PENALTIES

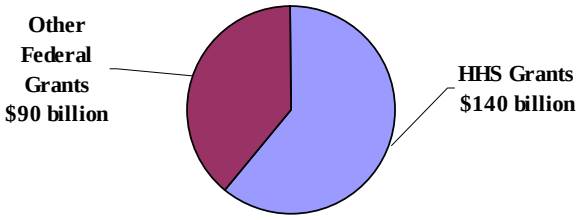
Civil Monetary Penalties (CMP) are non-criminal penalties for violation of Federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 provides for periodic evaluation to ensure that CMPs maintain their deterrent value and that the imposed penalties are properly accounted for and collected.

HCFA is the only OPDIV that has CMPs. Our FY 1997 CMP Report is summarized below.

GRANTS MANAGEMENT

As the largest granting component in the Federal Government, the Department of Health and Human Services (HHS) plays a key role in the Federal grants management arena. Through its 300 plus assistance programs, HHS awards $140 billion of the total Federal grants awarded (estimated to be nearly $230 billion).

Federal FY 1997 Grants



FY 1997 Civil Monetary Penalties Report

Outstanding Receivables	Number	Amount (in Dollars)
Beginning FY 1997 Balances	113	41,347,561
Assessments (+)	97	185,980,271
Collections on Receivables (-)	55	33,134,750
Adjustments	1	2,780,076
Amounts Written Off	0	0
Ending Balance	154	191,413,006
a. Current Receivables	56	42144291
b. Noncurrent Receivables	98	149,268,715
Allowance	56	35,914,826
Net Receivables	98	155,498,180
Total Delinquent	27	37,216,990
Total Non-Delinquent	29	4,927,301

Stewardship and oversight responsibilities for HHS grant programs involve a variety of administrative functions being performed on an ongoing basis. These administrative functions include: assisting OMB in its revisions of key OMB Circulars pertinent to grants administration; providing training and developing related guidance documents on these revised OMB circulars; strengthening HHS indirect cost negotiation capabilities; updating internal Departmental grants administrative procedures; and developing a Department-wide grants management information system to organize and consolidate grants award data across all HHS grant programs.

During Fiscal Year 1997, HHS assisted OMB on several major policy issues involving the Government-wide cost principles. Examples of these issues which will result in either cost savings or enhanced clarity of policies include: locking-in indirect cost rates for the life of awards; and providing guidance on the promulgation of a new capitalization policy. In April, HHS issued ASMB C-10, "*Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government.*" This document provides guidance to State, local and Indian Tribal Governments in the implementation of OMB Circular A-87, the cost principles applicable to these entities.

Further, HHS provided substantial technical comments to OMB on its final versions of Circular A-133, "*Audits of Institutions of Higher Education and Other Non-Profit Institutions,*" and A-128, *"Audits of State and Local Governments."* (In addition to initially revising Circular A-133, during this time period, OMB subsequently revised A-133 again to incorporate A-128 guidance applicable to states.) In response to the FY 1996 financial statement audit findings related to grants management, in early FY 1998 the Department issued Departmentwide policy and procedures establishing a systematic approach to track and identify grantees' compliance with the Single Audit Act. The Department's Task Force identified and solicited audits from all covered grantees. This key process provides additional assurance of the fiscal integrity of grant funds.

HHS continued with its implementation of the Grants Policy Directive (GPD) System, which is replacing the Departmental Grants Administration Manual with current and concise policy guidance. During this period, HHS reissued the Introduction to the GPD System, evaluated numerous OPDIV implementations of individual directives and issued a concept paper to solicit comment on indirect costs and other cost policies related to grants in preparation for developing the corresponding policy directive.

To update HHS grants management staff on changes to the various OMB cost principles and audit requirements, as well as provide clarification on existing regulatory guidance and internal grants administrative policies, training sessions were conducted for headquarters and regional operations.

In Fiscal Year 1997, the Tracking Accountability in Government Grants System (TAGGS) operated a successful Prototype of the software, and initiated Phase I Implementation. Under Phase I, data for fiscal years 1995 and 1996 were successfully loaded to TAGGS from the Administration on Aging (AoA), the Administration for Children and Families (ACF), the Health Care Finance Administration (HCFA), and the grants system that supported former Public Health Service agencies. An active users group, involving both grants management and information resources management staff from every OPDIV meets monthly to ensure continuing success with Phase II Implementation.

GrantsNet, an Internet application, continues to provide on-line access to the most up-to-date policies, regulations, and other pertinent grants-related information.

http://www.hhs.gov/progorg/grantsnet

PROCUREMENT MANAGEMENT

In FY 1997, approximately 550 HHS procurement personnel awarded and administered nearly 900,000 procurement actions, worth more than $2.9 billion. Also, HHS obligated an additional $1.5 billion from the Medicare Trust Fund for contracts with Medicare intermediaries and carriers. These procurement actions and contracts helped to meet the Secretary's goals of ensuring cost-effective health care and human services; ensuring the integrity of the Medicare Program; enhancing health promotion and disease prevention, improving access to health care for all Americans; and providing adequate support for biomedical research. For example, ASMB worked in partnership with NIH to extend the main support services contract at the Frederick Cancer Research and Development Center for an additional 2.5 years, at a cost of over $500 million dollars — permitting HHS to achieve its critical AIDS and cancer research missions.

Major procurement accomplishments in FY 1997 include the following:

- The Department enhanced its customer-oriented, results-driven and GPRA-compliant Acquisition Performance Measurement and Improvement System by developing a contractor survey instrument, to help track the efficiency, timeliness, quality and cooperation of HHS contracting personnel and project officers — from an HHS vendor (external customer) perspective.

- The Department's Acquisition and Project Officer Training Program provided comprehensive, formal training for both contracting professionals and project officers. Contracting personnel used approximately 1,700 training slots and project officers used about 2,800 training slots. Moreover, HHS developed a CD-ROM instructional module that will provide cost-effective, customized, high-quality training for HHS project officers. The CD-ROM — and a supplemental 1-day project management workshop — will replace two 4-day platform-training courses. We estimate that over 25% of our project officers will take advantage of the optional CD-ROM during the next fiscal year. Also, the Department incorporated a class on performance-based service contracting in its regular course schedule; and conducted two special workshops in the high-profile area of Capital Asset/Earned Value Project Management.

- HHS used purchase cards to buy over $66 million of goods and services, an increase of 73% over the previous fiscal year.

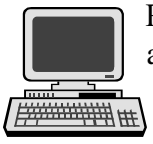
- HHS extended its automated capability, under the Federal Acquisition Computer Network (FACNET), by awarding simplified acquisitions (under $100,000) in an expedited fashion at HRSA. HRSA joined OS and a group of five OPDIVs — namely NIH, PSC, HCFA, FDA and CDC — which have previously utilized FACNET.

- HHS continued to enhance the query and reporting capabilities of its Departmental Contracts Information System as well as the reliability, timeliness and utility of its procurement management data — to better support executive decision-making.

- On behalf of the Department, NIH improved HHS' source selection and contract management processes by developing a user-friendly, high-tech, flexible, interactive and secure database system that efficiently and effectively collects, maintains, and disseminates information on the past performance of contractors. To date, 800 users have subscribed to this system — from HHS, EPA and Treasury.

- HHS conducted a successful Acquisition Symposium, with over 400 contracting personnel in attendance. At the symposium, the Department arranged for a computer demonstration of NIAID's Paperless Acquisition System, as well as NIH's Automated Past Performance System. Also, we offered the audience unique acquisition management perspectives from Treasury, VA and NASA. Moreover, HHS discussed critical procurement topics such as: commercial contracting; Government-Wide Area Contracts; Task Order contracting; the Workforce Improvement Act; and the rewrite of Part 15 under the Federal Acquisition Regulation — which is designed to streamline the acquisition function, facilitate the purchasing of "best value", and infuse innovative techniques into the source selection process.

INFORMATION RESOURCES MANAGEMENT AND FINANCIAL INFORMATION SYSTEMS



The HHS Offices of Information Resources Management and Finance are working to improve the automated systems environment and technology, in part by applying the requirements for performance and results-based management, capital planning, and investment review contained in the Information Technology Management Reform Act (ITMRA) of 1996. The Deputy Chief Information Officer chairs the Departmental investment review board, and the Deputy Chief Financial Officer is a member. Policies on Capital Planning and Investment Control, Information Resources Management Planning, and Chief Information Officer roles and responsibilities have been developed and issued for OPDIV review. These policies will be finalized, and the Information Technology Investment Review Board convened to consider HCFA's next steps regarding Medicare Information Technology.

Internet

HHS formed The Internet Information Management Council, which is comprised of a Steering Committee and a Work Group. The creation of a Department-wide Internet Information Management Council (IIMC) brings together HHS agencies which are operating the World Wide Web on the Internet. The purpose is to provide a place for agency input and discussion of common issues, and to provide for policy, editorial guidance, and decision-making in disseminating information to the public.

The Steering Committee provides a focal point for leadership and resolution of HHS Internet information management and dissemination issues. It recommends and/or implements Departmental guidance or policy, as well as provides guidance and direction to the Work Group. Each OPDIV is represented on the Steering Committee along with primary participation by ASMB, ASPE and ASPA. The Council provides a forum to discuss, share and promote Internet tools and technologies to improve dissemination and management of information to benefit the Department's customers and partners.

The Continuous Improvement Program Internet Lab, which was the precursor to the IIMC, was established in June 1994. It was co-chaired by representatives from ASMB and ASPE, and was comprised of volunteers from throughout HHS who met weekly and provided a forum for developing the HHS Home Page and the HHS OPDIV Web sites. These activities helped to expand electronic access to the Department's public information through the use of the World Wide Web.

It also helped to promote technology to improve business practices by improving communications to HHS customers and partners.

The Lab helped to launch the following landmark HHS initiatives:

- the use of electronic public service announcements in HHS public service announcement campaigns;
- establishment of an HHS Gateway to serve HHS' partners;
- the additional reduction of paperwork by making many documents available via the Internet that before were available only in paper form, including the HHS FY 1997 and 1998 budgets, HHS's press releases and fact sheets, and the Departmental Appeals Board's more than 1,600 decisions.

The Lab also actively participated in interagency Internet work groups involving the White House, as well as Cabinet agencies, to improve government-wide Internet services. These accomplishments unveiled major shortcomings that threaten the Department's ability to keep up with the growth of Internet uses. For example, there was no Departmental central authority for:

- Coordinating the HHS corporate presence on the Internet that, from a customer-friendly user perspective, could insure consistency and encourage collaboration among the various HHS Web sites; and
- Directing and committing Departmental resources to carry out White House and interagency Internet information initiatives and activities.

The Department supports tens of thousands of Web pages representing its various OPDIVs, which are committed to making HHS information and services accessible to all Americans. The proliferation of the Department's Internet presence generated the need for a central coordination function to (1) provide a forum for HHS Internet users to share ideas and develop policies using a collegial approach and (2) insure that the HHS corporate presence on the Internet reflects consistency among the various HHS OPDIVs.

Year 2000

The Deputy Secretary has identified the Year 2000 (Y2K) date compliance project as the Department's number one information technology initiative. As Y2K approaches, the ability of computer systems to process dates correctly may be compromised. The problem results from the fact that many systems process years using a two-digit format, thereby causing an inability to distinguish dates between the two centuries. For example, if "00" is used to designate the year 2000, then calculations such as "00" - "95" result in -95 instead of 5. This date problem could trigger major system failures as well as the production of erroneous data if the date format is not adapted. Though this problem exists only in systems that use date fields, it is still far-reaching across all agencies, and all affected systems must be made compliant. Y2K compliance is defined as the ability of information systems to accurately process date information in the year 2000 and between the twentieth and twenty-first centuries. The Department's plan to address the Y2K problem includes the identification of computer systems; development of conversion strategies and plans; dedication of sufficient resources to conversion and testing of systems and programs; and the final implementation of converted systems by December 31, 1999. Financial systems are included in the overall systems conversion.

The Office of Information Resources Management, which is responsible for coordinating the Department's Y2K remediation effort, requires all of its OPDIVs to submit both monthly systems inventories and quarterly reports to measure progress. Incorporating the industry's best practices, OPDIVs follow a five-phase model: awareness, assessment, renovation, validation, and implementation. In an effort to speed compliance of the Federal Government's most important systems, the Office of Management and Budget (OMB) has changed the renovation stage deadline for mission critical systems from December 1998 to September 1998 and the implementation deadline for mission

critical from November 1999 to March 1999. All HHS mission critical systems, except for HCFA external systems, are currently projected to meet the March 1999 compliance deadline.

In addition to tracking basic system inventory information and meeting the OMB quarterly report requirements, OIRM is requiring a more detailed reporting at the system level. Beginning with data from November 1997, OPDIVs must track and manage their Y2K efforts using a standard format Excel spreadsheet. The spreadsheet will contain comprehensive information about OPDIV inventories and external interfaces, and will be submitted monthly.

The Y2K report also incorporates data exchanges, including interfaces with State governments, and systems beyond information technology, including biomedical devices, facilities, and telecommunications. The EDI/State Systems Subgroup of the CIO Council's Year 2000 Subcommittee worked with the National Association of State Information Resources Executives (NASIRE) to co-sponsor the "Pittsburgh Summit of State and Federal IRM Executives" convened by the Governor of Pennsylvania on October 28, 1997. The HHS CIO participated as a co-leader of the "Interfaces: Inventory and Compliance" executive session. The Department plans to concentrate efforts on interfaces during the next quarter to meet the goals and date targets set in Pittsburgh.

OIRM chairs the Biomedical Equipment Subgroup of the CIO Council's Year 2000 Subcommittee. The existence of the Y2K date problems in biomedical equipment could pose potentially serious health and safety consequences. The goal of the Biomedical Equipment Subgroup is to help ensure that the Nation's patient care services and medical research, both public and private, continue uninterrupted by the failure of medical devices and/or scientific laboratory equipment. To accomplish this goal, the Deputy Secretary of HHS, on behalf of all the agencies in the subgroup, has sent a letter and survey dated January 21, 1998 to all biomedical equipment manufacturers devices and/or scientific laboratory equipment. The letter and survey ask the manufacturers to identify non-compliant products. The manufacturers are responding, and information is currently being posted on a web site hosted by the FDA. The web site was opened for public browsing on March 6, 1997.

OPDIVs that own or manage facilities need to identify and correct those building systems that may have Y2K compliance problems. OPDIVs will assess their facilities and share their assessments with the Governmentwide Year 2000 Building Systems Subgroup, which is chaired by GSA. GSA is responsible for Y2K compliance for the facilities it manages.

The Department has provided the GSA Year 2000 Telecommunications Project Manager with a list of HHS representatives who are developing telecommunications equipment inventories for their respective OPDIVs. These inventories are being posted to a password-protected database on the GSA web site. Each OPDIV will be able to access only their own inventory and vendor database. The Department can access all OPDIV inventories. Each OPDIV will upgrade, replace, or retire noncompliant products.

The Department's OPDIV Chief Information Officers (CIOs) and Y2K Coordinators will continue to meet regularly on Y2K progress. The Deputy Secretary will also continue to receive quarterly briefings. The Department plans to act in a systematic and proactive manner to ensure that all systems meet the Y2K requirement for compliance.

Electronic Benefits Transfer (EBT)

The May 1994 Report to the Vice President entitled **"Creating a Benefit Delivery System That Works Better and Costs Less"** provided the blueprint for implementing a nationwide EBT System by March 1999 that provides Federal and State program beneficiaries access to their benefits. According to the Report, the goal of EBT is to use one card, which is user-friendly to provide unified electronic delivery of benefits under a federal-State partnership. In FY 1996, OMB transferred responsibility to GSA for coordinating Electronic Commerce (EC) initiatives governmentwide with agencies with a significant investment in EC, including HHS. OMB broadly defined EC to include the Electronic Benefits Transfer Program (EBT), formerly under the Federal EBT Task Force, whose functions were transferred to GSA. GSA has stated that its new role in EBT is as an agent for the participating agencies, and that GSA would leave program policy to the program agencies, including the USDA's Food and Consumer Service (FCS), which is the lead program agency for EBT, along with OMB and Treasury.

As one of the EBT Principals along with OMB, Treasury, GSA and the USDA/FCS, HHS continues to actively support the Vice President's goal of nationwide EBT. However, due to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which eliminated the Aid to Families with Dependent Children (AFDC) program replacing it with the Temporary Assistance to Needy Families (TANF) Block Grant, the Administration for Children and Families (ACF) has no ongoing role in EBT implementation. HHS also continues to keep apprised of EBT policies for their potential impact on States with regard to state-administered HHS programs including TANF.

The Office of Inspector General, since the inception of the EBT program, has also been active in its implementation. As a member of the Governmentwide EBT Risk Management Forum, OIG is helping to ensure that necessary control and accountability measures are installed in the system to prevent fraud and abuse and to promote effective, efficient and cost conscious delivery of benefits to recipients. This includes recommending card security measures and developing risk assessments. Currently, the OIG is working with other OIGs in the audit work group led by the Department of Agriculture OIG to develop system audit procedures for reviewing EBT benefit cards, access controls, processing controls, security management, payment controls and performance measures.

HHS is also participating in a GSA-supported contractor effort with the Western Governor's Association (WGA), on implementing EBT pilot programs under the WGA's Health Passport Program (HPP) in several western states (Wyoming, Nevada, and North Dakota). The pilots are scheduled to begin in 1998. This pilot effort involves the Medicaid program, as well as Head Start, Maternal and Child Health and CDC programs, in addition to the Agriculture Department's Women, Infants and Children (WIC) Program. GSA says that HHS program agencies, HCFA, ACF, PHS and CDC, will be directly involved in the regional pilots, in addition to Agriculture and the Urban Institute which is doing the evaluation of the pilots. GSA, with contractor assistance, will provide technical support and input on the technical aspects of the HPP evaluation. GSA is also working with the departments of Education, Social Security, Veterans Affairs and others to gather information about potential applications in those areas that may have some limited interface with HHS programs.

Electronic Funds Transfer (EFT)

HHS continues to aggressively pursue various alternatives to improve the timeliness of payments and to prevent fraud, waste and abuse. The use of EFT has been a priority in HHS and throughout the Department various efforts are ongoing to make more payments via electronic means in order to improve timeliness and to reduce the cost of making payments.

In FY 1997, HHS progress in the implementation of EFT environment included:

- Increased EFT payments to vendors and travelers
- 100% of PSC payments to grantees through EFT
- 98% of PSC salary payments through EFT
- Provided comments to Treasury on the final EFT proposed rule
- Improved the quarterly report process from OPDIVs of status of EFT payments

Performance Information Collection Systems

The GPRA programs will use existing technology, systems, and data sources as much as possible to acquire performance information. They will rely on their own, their partners, other sources and systems, and in a few cases, anecdotal information to accomplish this. Any revisions or new systems will have to be identified after the appropriate program goals and measures are developed. If revisions or new systems are required, then OPDIVs are encouraged to offset the additional needs by reducing or eliminating obsolete or unnecessary data and systems, consistent with the Paperwork Reduction Act and the Information Technology Management Reform Act. Some systems/data sources may be too costly or inaccessible, especially when third parties are involved. In that case, decisions will have to be made to identify alternative goals or measures, and perhaps alternative technology, systems, and data sources that will still provide some indicator of how successful programs are in achieving results.

Medicare Information Technology (MIT)

Based on lessons learned in the past four years, HCFA has reassessed the MIT (formerly known as the Medicare Transaction System - MTS) development strategy. Instead of focusing on the development of a single, standard automated Medicare payment processing system, HCFA is focusing on developing a target architecture, identifying the "gaps" between current system performance and the target, and assessing a strategy for moving to the future systems environment. HCFA is also concentrating its information technology efforts on meeting the processing requirements of the Balanced Budget Act (BBA) of 1997 and transition to three standard systems for Medicare intermediaries, carriers, and Durable Medical Equipment regional carriers for ongoing claims processing. In addition, HCFA is heavily involved in internal and external modifications required to update computer systems to handle the Year 2000.

Managed care enrollment has grown in the last four years, placing an enormous burden on the HCFA managed care system. BBA, which mandates significant changes to the Medicaid and Medicare programs, places additional demands on the managed care system. HCFA is conducting a thorough review of BBA requirements and will, with contractor support, incorporate the BBA Medicare + Choice requirements into our baseline set of business requirements to produce a complete, up-to-date set of baseline requirements for the managed care system. The baseline set of requirements will allow assessment of future systems development activities for managed care.

Compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996

The Federal Financial Improvement Act (FFMIA) of 1996 fundamentally does two things. It: (1) establishes, in statute, certain financial management system requirements that are already established by Executive Branch policies; and (2) establishes new requirements for auditors to report on agency compliance with these basic requirements, and for agency heads and agency management to correct deficiencies within a certain time period.

"In General – Each agency shall implement and maintain financial management systems that comply substantially with Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level."

Beginning with the audits of the FY 1997 Financial Statements of the HHS' OPDIVs, the auditors are required to report on whether or not the agencies are in substantial compliance with the requirements of the FFMIA. Where the OPDIVs are not in substantial compliance with the Act, each OPDIV must develop a remediation plan that describes the resources and milestones for achieving compliance.

For the FY 1997 audits, the Office of Finance (OF) worked closely with the OPDIVs, the OIG, and the auditors to assure that the same rules for substantial compliance were applied in all of the audits. OF worked with the OIG to help clarify the Federal financial management systems requirements per OMB guidance. OF also helped the auditors to determine what systems and applications were included in the Departmental single integrated financial management system and what systems/ applications were external to the Departmental system.

HHS concurs with the OIG that there are instances in which the Department's financial management systems do not substantially comply with some of the requirements of FFMIA. The weaknesses include 1) our financial systems cannot generate financial statements timely; 2) HCFA does not have an integrated system to capture expenditures at the Medicare contractor level; and 3) EDP control weaknesses exist at the HCFA Central Office, Medicare contractors and HHS' central personnel/ payroll system. HHS is developing a remediation plan to correct this situation and will include it in its Financial Management Five-Year Plan for FY 1999.

EDP Controls

HHS recognizes an increase in the need to protect the security of information technology systems and the data contained therein as it continues to adopt and employ new technological solutions to conduct business, and as the widespread transmission of information over networks increases. The need to protect against unwarranted interruption of operations, to assure the integrity and privacy of automated information, and to protect against the potential for fraud and abuse is vital. To deal with increasing security and privacy needs, HHS in FY 1997 began to revise Departmental security policies and guidance to keep pace with new developments (e.g., Internet use) with particular emphasis on the need to implement safeguards to detect fraud attempts early, as well as, to prevent the abuse of sensitive HHS information and systems.

In addition, in FY 1997, HHS' major OPDIVs were required to develop and implement corrective action plans to address each specific material and reportable "Electronic Data Controls" weakness identified as a result of the Department's FY 1996 audits and reviews. As a result, HHS' OPDIVs developed policies and implemented procedures and controls to:

- Prevent the use of easily guessed passwords;
- Assure that passwords are changed frequently;
- Limit, control, and monitor all access to sensitive data bases;

- Assure that system privileges and authorizations are tightly controlled and granted on a "need-to-have" basis, i.e., only to employees whose duties require such capabilities; and finally
- Assure that user access privileges and authorizations are revoked quickly when the need no longer exists.

MANAGEMENT ACCOUNTABILITY AND CONTROL

The prevention and elimination of financial losses attributable to fraud, abuse and waste remain the primary objectives of HHS management control efforts. Consistent with the revised OMB Circular A-123, ***Management Accountability and Control***, HHS program managers annually explain the activities that support their annual assurance statements to the Secretary. The Secretary in turn provides with this report the management control assurance for HHS as a whole that is required by the FMFIA. HHS program managers also continue to demonstrate accountability for management control by identifying and correcting management control deficiencies. In the Appendices of this Accountability Report, we have included FMFIA-style exhibits for seven material weaknesses. Three of these weaknesses are new weaknesses identified in FY 1997. The remainder were carried over from the HHS FY 1996 Federal Managers Financial Integrity Act (FMFIA) Report. HHS components together also reported the correction of four material weaknesses in FY 1997. Since the initial implementation of the FMFIA, HHS has identified 358 material weaknesses and material non-conformances, and has corrected 345 of those.

With the Accountability Report pilot program, the Congress and OMB have provided HHS the opportunity to meet one of its objectives in the FY 1997 HHS Financial Management Status Report and Plan. Improving the efficiency and effectiveness of HHS management accountability programs through the integration of FMFIA and audit follow-up functions with other management accountability programs is a significant objective of HHS. This Accountability Report, which fully incorporates HHS's FMFIA report and Management Report on Final Action (required under the Inspector General Act Amendments of 1988), is an important element of HHS efforts to meet that objective.

In FY 1997, the HHS Chief Financial Officer took additional steps to ensure that significant information about management controls identified in the audits of financial statements was integrated into the Department's FMFIA decision-making processes. This Accountability Report reflects that HHS CFO formally solicited decisions from the Heads of HHS OPDIVs and the CFO's own functional managers about reporting weaknesses identified by the OIG in the FMFIA section of this report. In its audit of the FY 1996 Departmental financial statements the OIG recommended that HHS consider reporting identified financial statement material weaknesses and reportable conditions in the Department's FMFIA report. The CFO's response to the OIG recommendation led to such a process throughout the Department, and resulted in the reporting of two new FMFIA material weaknesses in this report. In addition, however, the OIG's recommendation and the CFO's action also resulted in program managers specifically addressing in their assurances to the Secretary their commitment to the correction of all of the deficiencies cited in FY 1996 financial statement audits. HHS plans to maintain this action as a permanent feature of its FMFIA reporting to ensure that weaknesses identified in audits of financial statements are formally addressed by HHS program managers.

Management Report on Final Action

Under the Inspector General Act Amendments of 1988 (IGAA), HHS and other Federal agencies provide statistical summaries of actions taken to resolve monetary findings included in audits conducted on behalf of agency Inspectors General (IGs). In Appendix C of this Accountability Report, HHS has incorporated its report of final actions for the six-month period, April 1, 1997 to

September 30, 1997. In future Accountability Reports, HHS will provide reports on final action that cover an entire fiscal year.

The HHS management report of final actions provides the required statistical summaries of management actions related to monetary disallowances and recommendations to put funds to better use identified by the HHS OIG. This report, consistent with previous reports, demonstrates through the continuous flow of audit resolution actions that HHS has established an effective process to identify and collect disallowances, and to make management improvements and seek program improvements that will result in better use of funds. Beyond the strict requirements of the IGAA, however, HHS pays particular attention to the resolution of disallowances that are over one year old. Reflecting this commitment, concerted effort in HHS over the last six months of FY 1997, particularly within the Administration for Children and Families (ACF), has resulted in a 30% reduction in the number of uncollected disallowances over one year old, from 188 in March 1997 to 132 in September 1997. This is the lowest balance of unresolved disallowances over one year old since HHS began reporting these data under the IGAA in FY 1989.

FINANCIAL STATEMENT REPORTING

Financial statements are prepared for all twelve OPDIVs; the eight largest are audited. The audited OPDIVs account for 99.5% of total HHS assets and 99.5% of total HHS expenses. HCFA, FDA, CDC, and NIH prepare their own financial statements and the remainder are prepared by the PSC, which provides central accounting services. In addition to the Departmentwide statements, OMB only requires "stand-alone" audited financial statements for HCFA and IHS. However, HHS management believes that each OPDIV should take responsibility for its own financial management, and there is no better measure for financial accountability than a financial audit opinion from a professional independent third party.

Accounting Standards

Consolidation. In FY 1997, HHS prepared Departmentwide consolidating financial statements for the first time (the FY 1996 statements were combining rather than consolidating). This necessitated the identification of intra-entity transactions in order to make year-end adjusting elimination entries. These elimination entries were for relatively small amounts, and affected only the Statement of Operations and Changes in Net Position.

Social Insurance. Also in FY 1997, HHS worked closely with the staff of the Federal Accounting Standards Advisory Board (FASAB) on the development of a new accounting standard for social insurance. We want to help FASAB write a standard that will provide information about the Medicare Trust Funds that is useful to the taxpayers and to policymakers. The cash flows and the trust fund mechanisms are quite complex issues, and there are intergenerational issues that are central to the understanding of the operations of the Medicare programs. FASAB is working to ensure that financial statement users can better assess the sustainability of the social insurance trust funds. Additionally, FASAB is concerned with trying to clarify any misconceptions of the taxpayers that there might be a future liability (there is ***no*** liability under law or accounting standard) to today's workers who are contributing to the Medicare Trust funds via payroll taxes. In this Accountability Report, readers will find information on the Trust funds throughout the report, in addition to the information contained in the financial statement footnote disclosures.

Liabilities. HHS recorded liabilities for post-employment benefits, in accordance with FASAB Standard No. 5, "Accounting for Liabilities," which became effective for FY 1997 financial reporting.

Payment Error Rates. HHS continued to work on the claims error rate issue in FY 1997. Also, in the coming months, HHS expects to be involved with FASAB in discussions regarding error rates for program payments across the Government. This new area of FASAB endeavor was inspired by the pioneering work done at HCFA to determine an estimate of the Medicare fee-for-service program's payments made in error. HCFA and HHS were the first to disclose such information in the FY 1996 financial statement reporting cycle.

Claims Payment Accuracy

The FY 1997 HCFA financial statement audit reviewed claims payment accuracy in their assessment of HCFA's compliance with laws and regulations. The audit found that the median dollar value of improper Medicare benefits payments made during FY 1997 was $20.3 billion, or about 11 percent of the $177.4 billion in processed fee-for-service payment reported by HCFA in FY 1997. Although 98 percent of the claims were paid correctly based on information submitted, when subsequent medical documentation was requested from providers and the services were reviewed, the error rate jumped to 11 percent. Of the errors identified through this "look behind" review of claims, the OIG estimated that approximately 44% of the errors were due to insufficient or missing medical documentation. Another 36% of the errors were due to a lack of medical necessity.

By comparison, the FY 1996 audit found that the median dollar value of improper Medicare benefits payments was $23.2 billion, or about 14% of the $168.6 billion in processed fee-for-service payment reported by HCFA in FY 1996. Although the FY 1997 median dollar value of improper payments is $3 billion less than FY 1996's, the OIG cannot conclude that the FY 1997 error rate is statistically different than that projected in FY 1996. This means that the decrease could be attributed to any number of factors such as, the fact that different types of claims with different dollar values were selected in FY 1997.

The OIG recommended that HCFA continue to pursue the Corrective Action Plan, which was developed as a result of the FY 1996 audit. HCFA concurs and will continue its aggressive corrective actions. HCFA's corrective action plan is designed to decrease the error rate by doing more claims review, including documentation review, and encouraging providers to properly document the services they provide to Medicare beneficiaries. HCFA will continue to pursue activities which will increase our ability to pay claims correctly the first time, increase our pre-payment savings, and further reduce the Medicare claims payment error rate. The audit has demonstrated the need for HCFA to increase oversight to ensure provider compliance with Medicare reimbursement rules and regulations. HCFA will fully implement the corrective action plan in FY 1998. Therefore, as stated in the OIG's FY 1997 audit report, too little time had elapsed for the plan to significantly reduce the FY 1997 error rate. HCFA expects the full impact of the plan to be demonstrated in the FY 1998 error rate.

New Reporting Requirements for FY 1998. Several new reporting requirements become effective for FY 1998, which could affect our next audit opinion. These include the new accounting standards for revenue, property, plant, & equipment (PP&E), and supplemental stewardship reporting.

New Financial Statements. In FY 1997, HHS held preliminary Departmentwide discussions on the new reporting requirements for FY 1998 including those for cost accounting and the replacement of the Statement of Operations and Changes in Net Position with several other more complex statements. These new reporting requirements are a result of the new accounting standards being implemented for FY 1998. The amount of system changes which may be necessitated by these new requirements is undetermined, but the coordination efforts and policy guidance efforts needed to implement these new reporting requirements for FY 1998 will be substantial. This workload will have to be accomplished by the same personnel who are also responsible for resolving a multitude of audit findings, instituting new reconciliation processes, and maintaining daily accounting operations.

Managerial Cost Accounting. In the private sector, cost accounting is used for internal purposes, rather than for external financial reporting. It (and the systems that support it) must be flexible enough to track costs and profits by product, location, sales person, or any number of other "cuts." Recently promulgated Federal generally accepted accounting principles (FedGAAP), have required cost accounting for external financial reporting purposes beginning in FY 1998, replacing the Statement of Operations with the Statement of Net Costs. With the new requirements to capture and report the full cost of producing and delivering specific products and services as well as to support GPRA requirements, cost accounting is presenting agencies with a tremendous challenge beginning FY 1998. HHS realizes that this requirement is much more than a financial statement requirement. It institutes the start of Departmentwide cost accounting, a key concept in performance management. Cost accounting takes financial accounting a step further by requiring the identification of indirect costs, as well as direct costs, to HHS's programs to determine the "full cost."

During FY 1997, HHS began preparing for the new statement. We contracted with a consultant firm to propose various implementation strategies and reporting formats, and to help us identify the challenges that need to be addressed. The contract will be completed during FY 1998. Several entities within HHS have already been operating in a cost accounting environment; most notably the revolving funds that operate on a fee-for-service basis. However, managerial cost accounting is a new requirement for the vast majority of HHS reporting entities.

We have many important issues remaining to be addressed in FY 1998, which will need policy guidance. A few of these issues which affect both OPDIV and Departmentwide reporting, are "full cost" identification, cost allocation methodology, and identification of those programs to be presented in the new statement.

FINANCIAL STATEMENT AUDIT FINDINGS AND MANAGEMENT COMMENTS

HHS received a qualified opinion on the Departmentwide FY 1997 financial statements. The following qualifications (scope limitations) were cited:

- Medicare and Medicaid Accounts Receivable
- Cost Report Settlements
- Grant Expenses (including year-end accruals)
- Net Position Balance
- Intra-Entity Departmentwide Transactions

Scope Limitation

A scope limitation occurs when adequate audit evidence cannot be collected. A scope limitation occurs when (1) available accounting records do not provide adequate audit evidence to support the amounts reported in the financial statements, (2) time available to complete the audit did not permit the application of all necessary audit procedures, or (3) because of restrictions placed on the audit by the auditee. The scope limitations identified in the OIG's report stem from conditions number (1) and (2).

The FY 1997 qualified opinion is a significant improvement over the disclaimer received for FY 1996. The trends in audit coverage expansion and in opinion improvement for HHS and the OPDIVs are summarized in the accompanying chart.

Audit Opinions

Disclaimer of Opinion – Issued when the auditor has not collected sufficient evidential matter to form an opinion on the financial statements. The effects are so material that it would be inappropriate to issue a qualified opinion.

Qualified Opinion – Issued when there is 1) a lack of sufficient evidential matter, or 2) a departure from Generally Accepted Accounting Principles (GAAP).

Unqualified Opinion (Also known as a **"Clean Opinion"**) – Issued when 1) accounting principles used are appropriate, 2) disclosures are adequate, 3) data is presented in a reasonable manner, 4) underlying events and transactions are fairly reflected in the financial statements, and 5) the financial statements have not been materially affected by changes in accounting principles.

Statement on Auditing Standards (SAS) 70 reviews and/or agreed-upon procedures reviews were conducted at the following locations, and the auditors findings from those reviews were incorporated into the Departmentwide auditor's report:

Payment Management System, PSC
Division of Computer Research and Technology, NIH
Central Payroll and Personnel System, PSC
Division of Financial Operations, PSC

SAS 70 – a review of the internal control structure of an organization that processes transactions or accounts for assets or liabilities of another entity.

HHS Financial Statement Preparation and Audit
Three Year History

Entity	FY 1995			FY 1996			FY 1997		
	Prepared	**Scope of Review/ Audit**	**Report/ Opinion Rendered**	**Prepared**	**Scope of Review/ Audit**	**Report/ Opinion Rendered**	**Prepared**	**Scope of Review/ Audit**	**Report/ Opinion Rendered**
HHS	Prototype - combined	Unaudited	No	Yes – combined	Full scope	Disclaim	Yes – consoli-dated	Full Scope	Qualified
HCFA	Yes	Limited Scope (Balance sheet only)	Disclaim	Yes	Full scope	Disclaim	Yes	Full Scope	Qualified
ACF	Yes	Pre-audit survey	Manage-ment Report	Yes	Full scope	Qualified	Yes	Full Scope	Qualified
NIH	Yes	N/A	N/A	Yes	Internal Control Assessmt	Manage-ment Report	Yes	Full Scope	Qualified
HRSA	Yes	N/A	N/A	Yes	Full scope	Qualified	Yes	Full Scope	Qualified
CDC/ ATSDR	Yes	N/A	N/A	Yes	Internal Control Assessmt	Manage-ment Report	Yes	Full Scope	Qualified
SAMHSA	Yes	N/A	N/A	Yes	Full Scope	Qualified	Yes	Full Scope	Qualified
IHS	Yes	Limited Scope (Balance Sheet only)	Disclaim	Yes	Full Scope	Qualified	Yes	Full Scope	Qualified
FDA	Yes	Pre-audit survey	No	Yes	Full Scope	Qualified	Yes	Full Scope	Qualified
AoA	Yes	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A
AHCPR	Yes	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A
PSC	Yes	N/A	N/A	Yes	SAS 70s	N/A	Yes	SAS 70s	N/A
OS	Yes	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A

N/A = not applicable

Comparison of Audit Findings: FY 1996 and FY 1997

The following chart summarizes the progress made from FY 1996 to FY 1997 on resolving qualifications (scope limitations) and material weaknesses.

Comparison of HHS Audit Findings: FY 1996 and FY 1997

Issue Category	1996		1997	
	Qualification Causing Disclaimer of Opinion	Material Weakness	Qualification Causing Qualified Opinion	Material Weakness
Medicare Accounts Payable	X	X*		X
SMI Revenue	X			
Medicare/ Medicaid Accounts Receivable	X	X*	X	
Cost Reports	X		X	
Net Position	X	X	X	**
Pension Liability	X			
Initial Audit	X			
EDP Controls		X		X
Grants Oversight and Accounting		X (includes oversight)	X (excludes oversight)	X (excludes oversight)
Medicare Claims Error Rate		X		X
Intra-Entity Dep'twide Transactions			X	
Financial Reporting				X**
TOTAL	7	5	5	5
Resolved From Prior Year	Not Applicable	Not Applicable	4	1**
New	7	5	2	1

*Consolidated into one material weakness citing both accounts payable and receivable in FY 1996.
**Net position issue from 1996 was consolidated into financial reporting issue in FY 1997.

Limitations of the Financial Statements

In accordance with OMB Bulletin 94-01, "Form and Content of Agency Financial Statements," we are disclosing the following limitations of the HHS FY 1997 financial statements, which are contained in this Accountability Report.

- The financial statements have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of the Chief Financial Officers (CFO) Act of 1990, as amended by the Government Management Reform Act (GMRA) of 1994.
- While statements have been prepared from HHS' books and records in accordance with the formats prescribed by OMB, the statements are different from the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.
- The statements should be read with the realization that they are for a component of a sovereign entity, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation, and the payment of all liabilities other than for contracts can be abrogated by the sovereign entity.

As with other Departments, the HHS Accountability Report is issued as quickly as possible after the auditor's findings on the FY 1997 Departmentwide audit are released. Therefore, there is little time to develop detailed plans for correcting audit findings. In the accompanying chart, we briefly summarize the auditor's findings and report on the status and/or plan of action regarding the resolution of the respective findings. In keeping with the U.S. CFO Council's "streamlining" philosophy of issuing one "accountability" document and one "planning" document per year, *the Department's* ***Financial Management Five-Year Plan*** *(to be published later this year) will provide more detailed information on our plans and goals for improving our opinion and resolving our audit findings.*

Departmentwide FY 1997 Audit Findings: Status and Plans

Issue Category	Significance to Opinion/ Auditor Assessment	Description	Status/Plan as of Accountability Report Publication
Medicare and Medicaid Accounts Receivable	Qualification (Scope Limitation)	Medicare receivables accuracy are dependent upon contractor systems and documentation; Medicaid receivables accuracy is largely dependent on a survey-based estimate of the States for an accrual of amounts due but not yet reported.	Medicare/Medicaid Accounts Receivable (A/R)- Medicare A/R are valued at $2.5 billion. Medicaid A/R is valued at $450 million. It was HCFA's plan to attach an integrated accounting system to the MTS system, and after that project was cancelled, to the shared systems used by the Medicare contractors. Long term plan continues to be an integrated accounting system. Short term plan will focus on ways to support the receivables reported with the contractors' existing subsidiary systems to improve the quality of data, and to identify and document the audit trails necessary to support and validate the data reported to HCFA. We have already requested the Medicare contractors to keep a complete audit trail including "systems snapshots" at the end of each quarter. HCFA has scheduled visits by technical teams to visit Medicare contractors to review systems, reconcile financial data, and ensure that appropriate audit trails are available.
Medicare Cost Report Settlements	Qualification (Scope Limitation)	Cost Report Settlements were valued at $2.4 billion in FY 1997. The cost report settlement process, represents the value of net outlays to providers based on fiscal intermediary (FI) audits of providers' cost reports. The cost report represents the costs incurred by a facility to provide Medicare services.	Government audit standards would allow the OIG to rely on the HCFA Provider audit process if it were based upon a methodology that would permit a representative sample of cost reports to be audited. HCFA has focused the limited scope audits on those providers that have a greater potential for overpayment in order to recover misspent Medicare funds and to provide a sentinel effect on all providers rather than to audit a random sample.
Intra-Entity Departmentwide Transactions	Qualification (Scope Limitation)	Minimal operational impact or risk of lost dollars. Related to management's ability to identify transactions within the OPDIVs and between HHS entities so that they will not be double-counted in the financial statement.	Policy guidance was issued during FY 1997; will be expanded during FY 1998.

Issue Category	Significance to Opinion/ Auditor Assessment	Description	Status/Plan as of Accountability Report Publication
Net Position Account Balances	Qualification (Scope Limitation)	This issue is the result of many years of unreconciled account balances, often due to re-organizations. The total net position balance is acknowledged by auditors to be correct, but two component account balances are in question.	Account reconciliations will continue until resolved.
Grant Expenses/ Accounting	Qualification (Scope Limitation)/ Material	*Grant Accrual* - Organization is impacted to the extent that resources are absorbed to calculate an estimate for year-end accruals, which is only used in financial reporting, in conformance with accounting standards. *Advance Reconciliation* – Resources will need to be dedicated in increasing/improving reconciliations between general ledger accounting and Payment Management System (PMS) records.	*Grant Accrual* - HHS, having already made significant progress by designing the accrual estimation technique during FY 1997, will continue to work with auditors to increase their comfort level with the estimating process through verification. *Advance Reconciliation* – Management agrees on the need for increased reconciliation processes, in order to ensure that grants disbursements are accounted for properly (such as charged to the correct annual appropriation). We have controls in place to ensure that grant recipients receive the correct amount of grant funds.
Financial Reporting	Material	This issue regards the present methods of financial statement preparation which are time-consuming and our manual reconciliation processes with Treasury, payroll systems, net position accounts, etc., which are not performed regularly.	We will investigate possibility of new software programs that may increase the efficiency of report preparation.

Issue Category	Significance to Opinion/ Auditor Assessment	Description	Status/Plan as of Accountability Report Publication
Medicare's fee-for-service program error rate (national compliance)	Material	Significant operational impact and risk. Indication of possible unnecessary or unallowable expenses. FY 1997 errors were estimated at 7-16% (for a mid-point estimate of $20.3 billion) of the program payments.	HCFA has conducted extensive training to health care providers, which improved the availability of documentation in the FY 1997 audit, bringing the estimate of improper payments down from a range of $17.8-28.6 billion (mid-point of 14%) in FY 1996 to $12.1-28.4 billion (mid-point of 11%) in FY 1997. The FY 1997 testing was expanded to include Durable Medical Equipment (DME) suppliers, and a higher error rate could reasonably have been expected. HCFA's corrective action plans include: recovering overpayments identified during sample testing (done); increasing contractor Medical Director FTEs by 15% (done); developing integrity pilot programs (3 are under development); hosting informational meetings with major provider professional organizations (underway); requiring surety bonds of DME suppliers (done); implementing the National Provider System; using technology and statistical methods to detect patterns of abuse (being developed); and developing an internal (vs. OIG) HCFA program for substantive testing.
Medicare Payables	Material	Accuracy of estimate is required by accounting standard, but will not delay or otherwise impact any payments made to insurance carriers. Does not impact actual payments made.	HCFA plans to continue to refine the estimating process. The formula is considered acceptable, but the source data fed into the formula needs to be more accurate.
Electronic Data Processing Controls	Material	Concerns validation of data input and physical access.	This is largely a HCFA issue, in central office and at contractors. Physical access controls will continue to be strengthened, and solutions are likely in FY 1998. Data input controls will require analysis and prioritization.
Grants Monitoring	Reportable	Auditors want to ensure that Single Audit reports filed by grantees are appropriately tracked and monitored.	In late FY 1997 a Task Force was established, and early FY 1998 a written policy was issued providing guidance to strengthen grants monitoring of Single Audits.
Property, Plant, & Equipment (PP&E) – Accounting and Management	Reportable	Some historical records cannot be located in order to properly value property. In other instances, property (such as research equipment) has not been located.	NIH and FDA will continue to improve their annual inventory procedures for property. IHS will complete the evaluation of its real property and complete its reconciliation of all personal property.
Estimating Losses for Pending Litigation	Reportable	This is a common problem, even in the private sector, because legal counsel is reluctant to release information about potential losses.	Management will try to obtain contingent claims data for report disclosure and obtain necessary information from Justice on claims paid by the Treasury Judgement Fund, but these will be a lower priority.

Benefits of the Financial Statement Audit Process

In the years since the CFO's Act of 1990 was enacted, which began requiring audited financial statement of selected Federal entities, HHS has welcomed and benefited from those audits.

Entities subjected to the financial statement audit process get an unbiased third party evaluation (often from independent certified public accounting (CPA) firms) of financial management processes, internal controls, and financial information systems, all of which are the source of information presented in the financial statements, and which serve to ensure proper stewardship of our resources and assets. The auditor also attests to the fairness of the information presented in the financial statements. Audit opinions of CPA firms are held in high regard by the public. Certainly, few investors would purchase stock in a publicly held company if that company could not satisfy its auditors of the fairness of its financial statements. Even though the audits of HHS' financial statements have cited numerous weaknesses, they have helped us identify the need for targeted corrective actions.

In the Federal environment, auditors are often evaluating systems and processes that have been in place years before there were financial reporting requirements that must meet today's given set of quality standards. The standards initiated by the Federal Accounting Standards Advisory Board (FASAB) have only been in effect since 1993/4 at the earliest, and some of the more demanding standards are still being phased in. Meanwhile, many HHS financial systems have been in operation for decades, though most have had major upgrades. Even the newer systems will need significant modifications to be in compliance with new accounting standards which are being implemented. We have many challenges ahead if we are to resolve our weaknesses and obtain a "clean" auditor's opinion. Fortunately, when an independent third party reports that a weakness is significant enough to have an impact on the reliability of the entity's financial reports and operations, it helps management to properly prioritize resources among competing activities and helps to ensure that problems are appropriately addressed.

Here are just a few of the benefits derived from the financial statement audit processes at HHS:

- Improved property management reporting and practices at all OPDIVs.
- Improved accounting for and management of grant dollars.
- Improved electronic data processing (EDP) controls over physical and data access.
- Improved timeliness and usefulness of financial reporting.
- Improved reconciliation processes for payroll and fund balance with Treasury.
- Quantified the error rate for Medicare fee-for-service program, facilitating targeted responses to minimize future errors.
- Improved accountability, maintenance of internal controls, and adherence to policies, procedures and standards.
- Broader-based management commitment toward timely implementation of corrective action plans, motivated by the public nature of the audit reports and statutory reporting deadlines.
- Increased information on operations, financial condition, and internal controls available to the public.
- Improved report generation programs to support audits and help verify account balances.
- Improved ability of interested parties to evaluate the true financial condition of HHS programs as represented by accrual accounting, rather than the cash-oriented budget.